
PERMANENT WARD SERVICE PLAN REQUIREMENTS

The DHS-68, Permanent Ward Service Plan (PWSP), is used by the foster care worker to record the progress of services and ongoing planning for all permanent wards (MCI wards and permanent court wards). The PWSP may be used as a revised case service plan in court reviews by adjusting the time frame for completing it to coincide with the schedule for reviews. For more detailed information on requirements, see FOM 722-09, **Updated Service Plan**.

During this transition period to SWSS use, there will be a difference in service plans produced by the placement agency foster care PAFC providers (templates) vs. service plans produced out of SWSS. The following are procedures for completion of the PWSP (RFF 68) (placement agency foster care providers are still accountable to follow policy). DHS workers must complete all service plans in SWSS.

Which Cases

- All open foster care cases with permanent ward status.
- If the child is placed in a residential care setting, the residential care provider will complete the DHS-366, Foster Care Residential Updated Service Plan. The DHS worker **must** also complete the PWSP because the residential service plans do not address monthly contact documentation by the DHS worker, the recommendations to the court and the (compelling reasons) or reasonable efforts as required by state and federal law. DHS workers are not required to duplicate information in the PWSP; they may reference the residential care plan, if appropriate.

Decisions

Service planning for permanent wards including:

- Services based on identified needs and strengths.
- For youth age 14 and older, independent living preparation services.
- Permanency planning and preparation.

**PWSP Time Frame
and Completion
Requirements**

The first PWSP must be completed after termination within the appropriate quarter and at least every 90 calendar days thereafter or more frequently, if necessary, to ensure coordination with court hearings.

At a minimum, the PWSP must be updated and revised at 90-day intervals. The due date of the PWSP is within 90 calendar days of the previous service plan's report period end date. A copy of each PWSP is required in every child's case record regardless of individual court reports.

The PWSP is considered complete when the DHS foster care worker submits it to the supervisor through SWSS-FAJ. The completion date is reflected in the report date text field on the first page of the PWSP.

The placement agency foster care (PAFC) PWSP is considered complete when the PAFC worker submits the PWSP to the PAFC supervisor for review. The completion date is reflected as the report date on the first page of the PWSP.

The PWSP is considered overdue if the report date is on or following the 91st day from the previous service plan's report period end date.

**Appropriate
Completion**

Prior to completing the narrative section of the PWSP, the foster care worker first reassesses the permanent ward's needs and strengths using the Child Assessment of Needs and Strengths, DHS-432, 433, 434, 435. See the instructions in FOM 722-08B on completion of the age appropriate Child Assessment of Needs and Strengths.

Goals and objectives written in the Treatment Plan and Service Agreement must address the priority needs identified for the child. Other needs for the child are addressed as necessary in the service plan.

**DHS-68,
PERMANENT WARD
SERVICE PLAN
INSTRUCTIONS**

The DHS-68 (RFF 68) must be used in the development of a PWSP for all permanent ward neglect/abuse children for whom the department is responsible. **All items in this format must be addressed unless otherwise noted.** Hidden text is in italics. See FOM 722-08, Accessing Hidden Text within structured decision making (SDM) templates for more information.

**Identifying
Information**

Report Period: List the report period covered (maximum 90 calendar days).

Date Report Completed: The date the report is completed.

County of Referral/Commitment:

Court Docket #:

Child(ren):

- Name.
- Birth date.
- SWSS FAJ log number.
- Case number.
- Child gender.
- Child race.
- Height.
- Weight.
- Hair color.
- Eye color.
- Religion.
- Federal permanency planning goal.
- Current legal status, date of current placement, date entered care.
- Current placement type.
- Anticipated next placement, date anticipated next placement.
- Native American question asked, tribe (if applicable).
- Provider name if relative or unrelated caregiver; name and address; if institution, name and address of institution; if licensed foster home, note foster home placement only.

I. Legal Status

- A. Court History - Child(ren): (list separately) name, petition date, petition type, hearing date, hearing outcome, order date, order type, requirements of the court through its order.
- B. Next Court Date.

II. Reasonable Efforts

Efforts made by the department/placing agency to place the child in a permanent placement in a timely manner; see FOM 722-06, Reasonable Efforts.

If services were not provided, explain the reasons why services were not provided.

Note: For children who are or who may be Indian children, active efforts are required; see NAA 205.

III. Social Work Contacts

- List date, person(s) contacted, role/position of person contacted, type of contact method (telephone, face-to-face, home visit, office visit, etc.) for each contact, scheduled, kept or unkept.
- Provide a brief narrative statement (2-3 sentences long) of the specific topics covered during the contact; see FOM 722-06, Visitations.
- For face-to-face contacts with foster children, include a statement whether the foster care worker had a private meeting with the child(ren), viewed the child(ren)'s sleeping arrangements and had a conversation with the caregiver regarding safe sleep requirements in applicable cases.
- The following face-to-face contacts must be documented in social work contacts, regardless of whether the primary foster care worker was part of that contact:
 - Parent/primary foster care worker contacts.
 - Child/primary foster care worker contacts.
 - Caregiver/primary foster care worker contacts.
 - Home visits.
 - Parenting time.

IV. Progress Summary

- Permanency planning conferences.

A. Child Reassessment

1. Child Needs and Strengths and Current Status - Indicate, for **each** permanent ward;

- Address and explain each individual item scored as a strength or need on the age appropriate Child Assessment of Needs and Strengths.
- Identify the priority needs of the child(ren) for service.

Priority needs are defined as those domains scored with the highest negative point value that is not a situational concern.

- Identify Situational Needs.

Situational concern is defined as an issue identified for a child that is short-term. Situational concerns **must not** be identified in consecutive service plan periods. If the issue persists beyond the case planning period, it would then be identified as a need.

- Identify other needs.

Other needs are any domains that have a negative score that are not considered priority or situational needs.

- Identify and explain strengths.

Strengths are defined as any domain scored with a "0" or positive number.

2. Placement Information

- Child(ren)'s name (list separately), living arrangement, begin date, end date, and the reason for replacement.
- Any replacements during the report period and the efforts made to prevent these replacements.

- Any change in the placement household during the report period, including any new adults moved into the household and results of the criminal history and central registry checks on those adults.
 - Child(ren)'s feelings and observations about current placement.
3. **Child(ren)'s Current Status** - Describe for **each** child under court jurisdiction:
- Significant events since the last assessment.
 - A physical description including distinctive characteristics.
 - Participation in extracurricular/cultural/hobbies, likes and dislikes.
 - Emotional and physical development.
 - Relationships with siblings, if applicable.
 - Behavior, and past experiences.
 - How the child(ren)'s permanency plan was shared with the child(ren) and child(ren)'s feelings about the plan.
4. **Educational Information** - For all elementary or secondary school students, document the child/youth's full-time school attendance with a statement that the child is a full-time student. If a child/youth is incapable of attending school on a full-time basis due to a medical condition, address incapability. Documentation of child's/youth's medical condition (from a medical provider) must be in the case plan and updated quarterly. Describe for **each** child:
- Child's name.
 - School name.
 - Grade.
 - Reassessment of the child's educational needs and strengths, based on information obtained from the initial screening of the child and current information.

- Special education information, if applicable.
- Child's current academic performance and behaviors in school, including whether a child is passing or failing their grade.
- Description of provided services from school, parent, foster parent and/or others to meet the child's educational needs.
- Child's and caregiver's comments about the child's educational needs and strengths.

If the child moved to another foster care placement (foster care replacement) during the report period the additional bullets must be addressed:

- The appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of removal.
- The best interest factors and the input of the parent or legal guardian, along with the education liaison used to determine the preferred school.
- Discussion of the transportation plan (if applicable).
- Verification that the child is enrolled in and attending school full-time within 5 business days of initial placement.
- Verification from the new school that child's previous school record has been obtained (if child's school is changed from the enrolled school at time of removal).

5. **Provision of Medical, Dental and Mental Health Services** - For **each** child complete the following:

- Child name.
- Current health status.
- Any needed emergency medical, dental and health care provided since entry into foster care.
- Date of full medical examination.

- Description of any needed medical follow-up appointments.
- Immunization status.
- Date of dental examination or date of scheduled appointment.
- Description of any needed dental follow-up treatment and appointments.
- List of prescribed and regularly dispensed over-the-counter medications, including dosage, diagnosis resulting in prescribed medication and prescribing physician.
- Documentation of informed consent for each psychotropic medication, if applicable.
- Date of mental health screening and/or assessment.
- Description of any needed mental health treatment, if applicable. Include name of treatment provider, frequency of sessions and treatment goals.
- Child's perception of their mental, medical and dental health needs, as applicable.

6. Placement Resources

a. Sibling Placement

- If the child has siblings who are not placed in the same out-of-home placement, provide an explanation of the reasons for the split.
- Describe the ongoing efforts to place the siblings within the same home.
- If sibling's placements are split, second line supervisory approval is required. The second line supervisor must sign the PWSP in the space designated at the end PWSP.
- If there are no siblings or if siblings are placed together, write N/A.

- b. **Sibling and Relative Visitation** - Visits are to occur at least monthly for siblings who are in separate placements. From the established sibling visitation plan in the Permanent Ward Treatment Plan and Service Agreement, document the following:

See FOM 722-06, Sibling Visitation and Ongoing Interaction.

- Dates of visits or contacts.
- Location of visits or contacts.
- Duration of visits or contacts.
- Specifically address and evaluate visits between siblings, if in separate placements.
- Ongoing interaction between siblings.
- If visits did not occur, document all reasonable efforts made to provide frequent visitation or other ongoing interaction between the siblings. Address and evaluate any relative visits including visits with adult siblings.
- If sibling visits have deemed harmful to the child, provide documentation supporting the reasons visits are not to occur.
- Specifically address and evaluate any relative/kinship network visits including visits with adult siblings.
- Include observations on the quality of the visits.
- Include a discussion of any exceptions (missed appointment, changed appointments, suspensions of appointments and changes in supervision status) to the plan during the reporting period.
- If there are no siblings or planned relative visits, write N/A in the space below.

- c. **Best Interests of Current Placement**

- Describe the foster parent/relative/unrelated caregiver's willingness and capacity to meet the specified needs of the child.
- Describe why the current placement is in the child's best interest.
- Document any CPS complaints regarding the caregiver, since the last report period, omitting any information about the CPS referral source.
- Document any foster home licensing complaint investigations regarding the caregiver since the last report period and any corrective action plans that were a result of the complaint.

7. Residential Care

- Describe the reasons for residential placement.
- Identify the plan for services that will allow the youth to be placed in a less restrictive setting.
- Regardless of child's age, if a child is placed in a residential or institutional setting, the foster care worker must document the Wraparound or assisted care efforts that were made to prevent the placement.
- If there were no services provided, explain why not.
- If the child is not placed in a residential or institutional setting, write N/A in the space provided.

8. Permanent Wardship

- a. For each child list the permanency planning goal.

Acceptable federal permanency goals are:

- Adoption.
- Guardianship.
- Permanent placement with a fit and willing relative.
- Placement in another planned living arrangement.

Describe the efforts made to finalize the permanency plan.

For each child, describe the:

- b. Child(ren)'s attitudes regarding termination of parental rights and adoption.
- c. Preparation of child for adoption.
- d. Possibility of adoption by foster parents/relative/unrelated caregivers.
- e. Effort made to place the child(ren) for adoption or within the relative network.
- f. Reasons why it is not in the child's best interest to be placed for adoption or within the relative network.

B. Foster Parent /Relative/Unrelated Caregiver Input

- Attach written input from the foster parent(s)/relative/unrelated caregiver for the child. If a written statement from the foster parent(s)/relative caregiver is not available, summarize the feedback; see FOM 722-06, Foster Parent/Relative caregiver Input.
- Document the date the child's Medicaid card was given to the foster parent/relative/unrelated caregiver.
- Describe the caregiver family's continued adjustment to the child(ren)'s placement.
- Document how the permanency plan for the child was shared with the caregiver and the caregiver's comments regarding the permanency plan.

V. Recommendation

Recommendations to Court, if applicable

- For each child, indicate whether the child should remain in placement, under the supervision of the court, as appropriate or as state wards.
- Request any other order from the court as appropriate.

**Supervisory
Approval**

Prior to finalizing, the PWSP along with the required assessments (FANS, CANS, etc.) must be reviewed and approved by the foster care supervisor only after a face-to-face meeting with the foster care worker.

Case service plan approval process requires the foster care supervisor to:

- Review and approve the PWSP within 14 calendar days of the report date.
- For DHS supervisors, select the Approved button in the SWSS-FAJ Supervisory Selection field to generate the SWSS-FAJ transaction.
- Sign and date the original approved case service plan.

The DHS and PAFC PWSP approval date is identified by the foster care worker and supervisor signatures and date on the last page of the PWSP. A copy of the PWSP with the two signatures and dates must be placed in the narrative section of the case record.

The agency is considered out of compliance with licensing rule R400.12403(2)(o) if the foster care supervisor signature date is past the 14-day review and approval time frame.

Note: At the time any agency receives the SWSS-FAJ conversion, that specific agency is required to comply with SWSS-FAJ policy specifications.

Supervisory approval indicates agreement with:

- The foster care worker's court recommendations within the service plan.
- Assessment of the child(ren)'s needs and strengths.
- Appropriateness of current placement.
- Current treatment plan.
- Permanency planning goal.
- Permanency planning and service provision.

Note: The plan must identify the unique needs of each child addressed in the service plan. The services which will meet the needs of each child as well as the identified provider's willingness and capacity to meet those needs.

The DHS-148, Structured Decision Making Children's Foster Care Case Reading Form, may be used when reviewing case compliance.

**PURCHASE
AGREEMENT -
LOCAL OFFICE
APPROVAL**

The local office must approve or disapprove, in writing, the PWSP for a child in a PAFC placement and/or residential care. See FOM 722-08, Initial Service Plan for detail on time frames and responsibilities.

**TREATMENT PLAN
AND SERVICE
AGREEMENT**

The Permanent Ward Treatment Plan and Service Agreement portion of the DHS-68 (RFF-68) must be updated each time a service plan is completed. For more information, see FOM 722-08C, Parent-Agency Treatment Plan and Service Agreement.

**DISTRIBUTION OF
CASE PLAN**

Indicate the distribution of the plan.